Sample 837 Scenarios

The sample scenarios are for test and education purposes. The information is test data and does not represent actual insurance carriers, employers, injured employees, or health care providers. The information may appear to be real or confidential information. However, this is done in order to ensure the test data passes validation edits.

TX 837 – Scenario 5

Physical Therapy
1 unit denied, 1 unit reduced

Darlene Davidson is a single female, born 06/04/69. She lives at 5720 Green Drive in Dallas, TX 72309. Her telephone number is (214) 836-5527 and social security number is 224-17-3272.

Darlene works at Bagels, Etc. located at 234 Main Street in Dallas, TX 72314. Bagels, Etc.'s telephone number is (214) 472-1462.

Bagels, Etc. is covered under policy number 147673A472 by Texas Insurance Company. Texas Insurance Company is located at 789 Airport Road in Austin, TX 60606-1234 and their telephone number is (312) 555-1470 and its FEIN is 76-533244.

- On 09/18/2002, Darlene hurt her lower back while lifting boxes at Bagels, Etc.
- From 08/19/03 through 08/21/03 she received physical therapy from Carl Bones, license number PT0000432TX who worked for Spines R Us, located at 345 Lower Level, Arlington, TX 62308. FEIN is 43-5621987.
- On 09/03/03 treatment Spines R Us sent a bill to Texas Insurance Company with charges totaling $190.00:
    - DOS 08/19/03; 97001; 1 unit; $100.00
    - DOS 08/20/03; 97110; 2 units; $60.00
    - DOS 08/21/03; 97033; 1 unit; $30.00

- On 09/06/03 Texas Insurance Company received the invoice from Spines R Us
- On 09/10/03 Texas Insurance Company sent payment to Spines R Us under IC claim number 14000714D, TWCC claim number 98-778642:
    - $100.00 paid for 97001
    - $0.00 paid for 1 unit of 97110 using ARC W9 and $25.00 paid for 1 unit of 97110 using ARC W1
    - $25.00 paid for 97033 using ARC W1

On 09/15/03 Texas Insurance Company sent a transaction to TWCC covering a reporting period of 08/02/03 to 09/01/03 including the IC unique bill number 333123.

PLEASE DO NOT STAPLE IN THIS AREA

Texas Insurance Company
789 Airport Road
Austin, TX 60606-1234

PICA

HEALTH INSURANCE CLAIM FORM

PICA

1. MEDICARE ☐ (Medicare #) MEDICAID ☐ (Medicaid #) CHAMPUS ☐ (Sponsor's SSN) CHAMPVA ☐ (VA File #) GROUP HEALTH PLAN ☐ (SSN or ID) FECA BLK LUNG ☐ (SSN) OTHER ☐ (ID)

1a. INSURED'S I.D. NUMBER (FOR PROGRAM IN ITEM 1): 224-17-3272

2. PATIENT'S NAME (Last Name, First Name, Middle Initial): Darlene Davidson

3. PATIENT'S BIRTH DATE MM DD YY: 06 04 69 SEX M ☐ F ☒

4. INSURED'S NAME (Last Name, First Name, Middle Initial): Bagels, Etc.

5. PATIENT'S ADDRESS (No., Street): 5720 Green Drive

6. PATIENT RELATIONSHIP TO INSURED: Self ☐ Spouse ☐ Child ☐ Other ☒

7. INSURED'S ADDRESS (No., Street): 234 Main St.

CITY: Dallas STATE: TX

8. PATIENT STATUS: Single ☒ Married ☐ Other ☐

CITY: Dallas STATE: TX

ZIP CODE: 72309 TELEPHONE (Include Area Code): (214) 836-5527

Employed ☒ Full-Time Student ☐ Part-Time Student ☐

ZIP CODE: 72314 TELEPHONE (INCLUDE AREA CODE): (214) 472-1462

9. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial): Texas Insurance Company

10. IS PATIENT'S CONDITION RELATED TO:

11. INSURED'S POLICY GROUP OR FECA NUMBER

a. OTHER INSURED'S POLICY OR GROUP NUMBER: 147673A472

a. EMPLOYMENT? (CURRENT OR PREVIOUS) YES ☒ NO ☐

a. INSURED'S DATE OF BIRTH MM DD YY SEX M ☐ F ☐

b. OTHER INSURED'S DATE OF BIRTH MM DD YY SEX M ☐ F ☐

b. AUTO ACCIDENT? YES ☐ NO ☐ PLACE (State)

b. EMPLOYER'S NAME OR SCHOOL NAME

c. EMPLOYER'S NAME OR SCHOOL NAME

c. OTHER ACCIDENT? YES ☐ NO ☐

c. INSURANCE PLAN NAME OR PROGRAM NAME

d. INSURANCE PLAN NAME OR PROGRAM NAME

10d. RESERVED FOR LOCAL USE

d. IS THERE ANOTHER HEALTH BENEFIT PLAN? YES ☐ NO ☐ *If yes*, return to and complete item 9 a-d.

READ BACK OF FORM BEFORE COMPLETING & SIGNING THIS FORM.

12. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE I authorize the release of any medical or other information necessary to process this claim. I also request payment of government benefits either to myself or to the party who accepts assignment below.

SIGNED _____ DATE _____

13. INSURED'S OR AUTHORIZED PERSON'S SIGNATURE I authorize payment of medical benefits to the undersigned physician or supplier for services described below.

SIGNED _____

14. DATE OF CURRENT: MM DD YY 09 18 02 ILLNESS (First symptom) OR INJURY (Accident) OR PREGNANCY(LMP)

15. IF PATIENT HAS HAD SAME OR SIMILAR ILLNESS. GIVE FIRST DATE MM DD YY

16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION MM DD YY FROM TO MM DD YY

17. NAME OF REFERRING PHYSICIAN OR OTHER SOURCE: James Boudreaux, MD

17a. I.D. NUMBER OF REFERRING PHYSICIAN: MDF1234TX

18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES MM DD YY FROM TO MM DD YY

19. RESERVED FOR LOCAL USE

20. OUTSIDE LAB? YES ☐ NO ☐ $ CHARGES

21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY. (RELATE ITEMS 1,2,3 OR 4 TO ITEM 24E BY LINE)

1. 847.2 3. ____.__

2. ____.__ 4. ____.__

22. MEDICAID RESUBMISSION CODE ORIGINAL REF. NO.

23. PRIOR AUTHORIZATION NUMBER

24. A DATE(S) OF SERVICE From MM	DD	YY	To MM	DD	YY	B Place of Service	C Type of Service	D PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS	MODIFIER	E DIAGNOSIS CODE	F $ CHARGES	G DAYS OR UNITS	H EPSDT Family Plan	I EMG	J COB	K RESERVED FOR LOCAL USE
08	19	03	08	19	03	11		97001		1	100 00	1				
08	20	03	08	20	03	11		97110		1	60 00	2				
08	21	03	08	21	03	11		97033		1	30 00	1				

25. FEDERAL TAX I.D. NUMBER SSN ☐ EIN ☒: 43-5621987

26. PATIENT'S ACCOUNT NO.

27. ACCEPT ASSIGNMENT? (For govt. claims, see back) YES ☐ NO ☐

28. TOTAL CHARGE $ 190 00

29. AMOUNT PAID $

30. BALANCE DUE $

31. SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING DEGREES OR CREDENTIALS (I certify that the statements on the reverse apply to this bill and are made a part thereof.)

Carl Bones PT0000432TX

SIGNED DATE 09/03/03

32. NAME AND ADDRESS OF FACILITY WHERE SERVICES WERE RENDERED (If other than home or office)

Spines R Us
345 Lower Level
Arlington, TX 62308

33. PHYSICIAN'S, SUPPLIER'S BILLING NAME, ADDRESS, ZIP CODE & PHONE #

Spines R Us
345 Lower Level
Arlington, TX 62308

PIN# GRP#

(APPROVED BY AMA COUNCIL ON MEDICAL SERVICE 8/88) **PLEASE PRINT OR TYPE** FORM HCFA-1500 (12-90) FORM OWCP-1500 FORM RRB-1500